UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

CIMZIA (certolizumab)for Crohn's Disease

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext.and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Diagnosis_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO: 801-536-0477

CRITERIA:

- Age requirement: 18 years and older
- Diagnosis of moderate to severely active Crohn's Disease.
- Documented inadequate response to conventional therapy (i.e. 5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine, azathioprine, coritcosteroids, or budesonide).

OR

- Documented intolerance to or loss of response on infliximab (remicade).
- Negative TB skin test or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Cimzia may not be given with other biologic agents such as Interferon, experimental medications or combination.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement with medication.